

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$4,880.63 for date of service, 08/06/01.
- b. The request was received on 07/29/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. Initial Submission of TWCC-60
 1. UB-92(s)
 2. Medical Audit summary/EOB/TWCC 62 form
 - b. Additional documentation requested on 08/06/02 – No response found in the file.
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60
 - b. UB-92 (s)
 - c. Medical Audit summary/EOB/TWCC 62 form
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 08/06/02. The Requestor did not submit additional information. There is a Carrier initial response but no Carrier 14 day response to this medical fee dispute. The initial response is reflected in Exhibit II of the file.
4. Notice of "No Carrier Sign Sheet" reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Noted on Table of Disputed Services

“The Carrier has not provided a proper payment exception code in this instance, which is in violation of the Texas Administrative Code.”

2. Respondent: Letter dated 07/24/02

“I am filing the TWCC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor’s dispute regarding fee reimbursement for August 6, 2001. As a result, there was a recommendation of reimbursement for this review, which was for the disputed amount of \$4,880.63.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/06/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$5,619.38 for services rendered on the above date in dispute.
4. Per the Requestor’s Table of Disputed Services, the Carrier paid the Requestor \$683.75 for services rendered on the above date in dispute.
5. Per the Requestor’s Table of Disputed Services, the amount in dispute is \$4,880.63 for services rendered on the above date in dispute.
6. The Requestor has submitted Carrier’s EOB(s), dated 10/01/01, that deny additional reimbursement as, “I01 BILLED AMOUNT REDUCED BASED UPON RECOMMENDATION OF UTILIZATION REVIEW VENDOR” and “195 The PPO reduction was calculated per your PPO contract.” However, the Carrier has submitted EOB(s), dated 02/04/02, that deny additional reimbursement as “M Reimbursement amount based on the Milliman & Robertson’s 1997 Ambulatory Surgery Guidelines, using the highest adjustment factor for the state of Texas and a fair and reasonable mark-up.” There is no MAR value for ambulatory surgical facility centers; therefore this dispute will be reviewed as reduced to fair and reasonable.
7. There is not a copy of any managed care contract with the Carrier noted in the file dispute packet.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate..."

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i) (1-4) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. The burden is on the provider to show that the amount of reimbursement requested is fair and reasonable.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine which party has provided the most persuasive evidence for the services provided. The Carrier has not submitted any evidence as to how they determined their reimbursement amount or proof of a managed care contract with the Requestor. No methodology was submitted as required by Rule 133.304 (i). The Provider, who has the burden as the Requestor, to prove its fees are fair and reasonable has not provided sufficient information that supports its fees billed are fair and reasonable. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 25th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt